

## Past Medical History

**Patient name:** \_\_\_\_\_

Please complete this form. The purpose of this questionnaire is to help us perform a thorough evaluation and further understand your condition.

**Please note that this form is considered part of your medical records and will be kept private and confidential.**

<b>Have you ever suffered or have been told that you have:</b>			
High blood pressure	<b>YES</b>	<b>NO</b>	
Heart problems	<b>YES</b>	<b>NO</b>	
Lung problems	<b>YES</b>	<b>NO</b>	
Head injury	<b>YES</b>	<b>NO</b>	
Multiple sclerosis/Parkinson's Disease	<b>YES</b>	<b>NO</b>	
Stroke	<b>YES</b>	<b>NO</b>	
Liver problems	<b>YES</b>	<b>NO</b>	
Thyroid problems	<b>YES</b>	<b>NO</b>	
Blood disorders	<b>YES</b>	<b>NO</b>	
Diabetes (high blood sugar)	<b>YES</b>	<b>NO</b>	
Low blood sugar	<b>YES</b>	<b>NO</b>	
Cancer	<b>YES</b>	<b>NO</b>	
Arthritis	<b>YES</b>	<b>NO</b>	
Osteoporosis	<b>YES</b>	<b>NO</b>	
Circulatory or vascular problems	<b>YES</b>	<b>NO</b>	
Broken bones (fractures)	<b>YES</b>	<b>NO</b>	
Other orthopedic problems	<b>YES</b>	<b>NO</b>	
Chronic pain	<b>YES</b>	<b>NO</b>	
Ulcers/stomach problems	<b>YES</b>	<b>NO</b>	
Chronic migraines	<b>YES</b>	<b>NO</b>	
<b>For men only:</b>			
• Prostate disease	<b>YES</b>	<b>NO</b>	
<b>For women only:</b>			
• Pelvic inflammatory disease	<b>YES</b>	<b>NO</b>	
• Endometriosis	<b>YES</b>	<b>NO</b>	
• Complicated pregnancies	<b>YES</b>	<b>NO</b>	
• Trouble with your period	<b>YES</b>	<b>NO</b>	
• Are you currently pregnant?	<b>YES</b>	<b>NO</b>	
<b>PLEASE TURN OVER</b>			<b>PLEASE TURN OVER</b>

<b>Have you recently experienced:</b>			
Weight loss/gain	<b>YES</b>	<b>NO</b>	
Pain at night	<b>YES</b>	<b>NO</b>	
Fatigue/malaise	<b>YES</b>	<b>NO</b>	
Difficulty sleeping	<b>YES</b>	<b>NO</b>	
Joint pain and/or swelling	<b>YES</b>	<b>NO</b>	
Urinary or bowel problems	<b>YES</b>	<b>NO</b>	
Nausea and vomiting	<b>YES</b>	<b>NO</b>	
Numbness or tingling, if yes where?	<b>YES</b>	<b>NO</b>	
Weakness in your arms or legs	<b>YES</b>	<b>NO</b>	
Coordination problems	<b>YES</b>	<b>NO</b>	
Difficulty walking	<b>YES</b>	<b>NO</b>	
Dizziness or loss of consciousness	<b>YES</b>	<b>NO</b>	
Chest pain	<b>YES</b>	<b>NO</b>	
Heart palpitations	<b>YES</b>	<b>NO</b>	
Shortness of breath	<b>YES</b>	<b>NO</b>	
Difficulty swallowing	<b>YES</b>	<b>NO</b>	
New onset of headaches	<b>YES</b>	<b>NO</b>	
Visual problems	<b>YES</b>	<b>NO</b>	
Hearing problems	<b>YES</b>	<b>NO</b>	
<b>Do you:</b>			
Smoke	<b>YES</b>	<b>NO</b>	
• If yes, how much? _____ ppd			
Drink alcohol	<b>YES</b>	<b>NO</b>	
• If yes, how much? _____			
Have any significant family history of illness or disease	<b>YES</b>	<b>NO</b>	
Other			

**Please list any medications that you are currently taking** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you had surgery or been hospitalized in the past? YES NO**  
Date/reason : \_\_\_\_\_

\_\_\_\_\_

**Who is the primary physician that you see most often?** \_\_\_\_\_

**How were you referred to us? (Please check)** Doctor  \_\_\_\_\_  
Friend/prior patient  \_\_\_\_\_ Insurance company  Internet   
Yellow Pages  Other  \_\_\_\_\_